General

Guideline Title

Guideline for prescribing opioids to treat pain in injured workers.

Bibliographic Source(s)

Washington State Department of Labor and Industries. Guideline for prescribing opioids to treat pain in injured workers. Olympia (WA): Washington State Department of Labor and Industries; 2013 Jul 1. 19 p. [41 references]

Guideline Status

This is the current release of the guideline.

Regulatory Alert

FDA Warning/Regulatory Alert

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- March 22, 2016 – Opioid pain medicines : The U.S. Food and Drug Administration (FDA) is warning about several safety issues with the entire class of opioid pain medicines. These safety risks are potentially harmful interactions with numerous other medications, problems with the adrenal glands, and decreased sex hormone levels. They are requiring changes to the labels of all opioid drugs to warn about these risks.

Recommendations

Major Recommendations

The Department of Health (DOH) pain management rules, 2010 Agency Medical Directors' Group (AMDG) *Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain*, and this Supplement are reflective of the practice standard for prescribing opioids for a work-related injury or occupational disease.

Opioid Use in Workers' Compensation

Measuring the Impact of Opioid Use

Beyond the acute phase, effective use of opioids should result in clinically meaningful improvement in function (CMIF). Providers should track function and pain on a regular basis, using the same validated instruments at each visit, to consistently determine the effect of opioid therapy. The department endorses the Two Item Graded Chronic Pain Scale as a quick, two-question tool to track both function and pain when opioids are prescribed (see AMDG Guideline, Appendix C at www.agencymeddirectors.wa.gov/Files/OpioidGdline.pdf).

CMIF is defined as an improvement in function of at least 30% as compared to the start of treatment or in response to a dose change. A decrease in pain intensity in the absence of improved function is not considered CMIF.

Other validated instruments may also be used to measure functional improvement (see AMDG Guideline, Tools for Assessing Function and Pain). The American Chronic Pain Association has created a 10-item Quality of Life Scale for people with pain, which helps correlate the Graded Chronic Pain Scale with actual daily activities. Use of the PROMIS web-based tool (www.nihpromis.org /) may also be helpful in determining the effectiveness of chronic opioid therapy (COT). Ultimately, effective COT should result in improved work capacity or the ability to progress in vocational retraining.

Evaluation of clinically meaningful improvement should occur at three critical decision-making phases:

1. At the end of the acute phase (about 6 weeks following injury or surgery), to determine whether continued opioid therapy is warranted in the subacute phase.
2. At the end of the subacute phase (3 months following injury), to determine whether to prescribe COT.
3. Periodically during COT, to assess impact on function and risk of therapy.

Continuing to prescribe opioids in the absence of clinically meaningful improvement in function or after the development of a severe adverse outcome is not considered proper and necessary care in the Washington State workers' compensation system. In addition, the use of escalating doses to the point of developing opioid use disorder is not proper and necessary care.

Opioid Prescribing Precautions

Opioid Use with Co-morbid Substance Use or Mental Health Disorders

Because of the increased risk for adverse outcomes from the use of COT in patients with mental health disorders, such as borderline personality disorder, mood disorders (e.g., depression, bipolar disorder, anxiety, post traumatic stress disorder [PTSD]) or psychotic disorders, providers should be cautious when prescribing COT for workers with these co-morbid conditions. Furthermore, workers with current substance use disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) (excluding nicotine) should not receive COT. Workers with a history of opioid use disorder should only receive COT under exceptional circumstances.

Drugs and Drug Combinations to Avoid

DO NOT USE

- Parenteral opioids in an outpatient setting
- Meperidine for chronic pain
- Methadone for acute or break-through pain
- Long-acting or extended-release opioids (e.g., Oxycontin®) for acute pain or post-operative pain in an opioid-naive worker

Use Is NOT RECOMMENDED

- Carisoprodol (Soma®)
- Any combination of opioids with benzodiazepines, sedative-hypnotics or barbiturates. *There may be specific indications for such combinations, such as the co-existence of spasticity. In such cases, a pain specialist consultation is strongly recommended. Consider alternatives such as tricyclic antidepressants or antihistamines to manage insomnia.*

Use with CAUTION

- Over-the-counter acetaminophen with acetaminophen combination opioids (e.g., Vicodin®, Norco®, Percocet®, Endocet®, Ultracet®)
- Tramadol or meperidine in patients at risk for seizures or who are taking drugs which can cause seizures (e.g., bupropion, serotonin reuptake inhibitors, tricyclic antidepressants)
- Methadone for pain. Due to methadone's nonlinear pharmacokinetics, unpredictable clearance and multiple drug-drug interactions, providers should use extreme caution when prescribing this drug for pain. Additional information is available at www.agencymeddirectors.wa.gov/opioiddosing.asp .

Prescribing methadone is complex (see the "Potential Harms" field). To prevent serious complications from methadone, prescribers should read and carefully follow the methadone (Dolophine®) prescribing information at www.accessdata.fda.gov/scripts/cder/drugsatfda/index.cfm .

Prescribing Opioids for a Work-related Injury or Occupational Disease

Opioids in the Acute Phase (0 to 6 Weeks after Injury or Surgery)

In general, opioid use for acute pain should be reserved for post surgery, for the most severe pain (e.g., pain scores ≥7), or when alternative treatments such as non-steroidal anti-inflammatory drugs (NSAIDs) and non-pharmacological therapies are ineffective. Evidence does not support the use of opioids as initial treatment for back sprain or other strains, but if they are prescribed, use should be limited to short-term (e.g., ≤14 days).

Pain intensity and pain interference should decrease during the acute phase as part of the natural course of recovery following surgery or most injuries. Resumption of pre-injury activities, such as return to work, should be expected during this period. If use in the acute phase (0-6 weeks) does not lead to improvements in pain and function of at least 30%, or to pain interference levels of 4 or less, continued opioid use is not warranted.

Labor & Industries (L&I) or insurer may cover opioids for up to 6 weeks when prescribed to treat pain from the acute injury or after surgery.

Providers should:

- Obtain baseline measures of pain and pain interference (function) within 2 weeks of filing a claim.
- Inform the worker that L&I or insurer will not pay for opioids beyond 6 weeks in the absence of clinically meaningful improvement in function.
- Help the worker set reasonable expectations about their recovery and return to work.
- Talk to the worker about safe storage and disposal of opioids and other controlled substances.
- Prescribe opioid(s) in multiples of 7-day supply to reduce the incidence of supply ending on a weekend.
- Document clinically meaningful improvement in function and pain with treatment.
- Explore non-opioid strategies to treat pain, including early activation.
- Use urine drug tests, the state's Prescription Monitoring Program (PMP) and other screening tools in the AMDG Guideline to ensure controlled substances history is consistent with prescribing record and worker's report.
- Determine pre-injury use of controlled substances and help the worker understand that L&I or insurer is not responsible for non-work-related treatment and conditions.
- Taper the worker off of opioids by 6 weeks.
- Request opioid authorization no later than 4 weeks post injury if continued opioid use is anticipated beyond 6 weeks to avoid abrupt cessation. See "subacute phase" below for authorization procedures.

Opioids in the Subacute Phase (between 6 and 12 Weeks)

With some exceptions, resumption of pre-injury activities such as return to work should be expected during this period. Use of activity diaries (www.agencymeddirectors.wa.gov/opioiddosing.asp#CME) is encouraged as a means of improving patient participation and investment in recovery. Non-pharmacological treatments such as cognitive-behavioral therapy, activity coaching, and graded exercise are also encouraged. If the injury is a sprain or strain, opioid use beyond the acute phase is rarely indicated.

If opioids are to be prescribed for longer than 6 weeks, the provider must seek authorization. With the exception of catastrophic injuries, the provider must perform the following best practices before L&I or insurer can authorize payment for opioids beyond the acute phase:

- Access the state's PMP to ensure that the controlled substance history is consistent with the prescribing record and worker's report.
- Document clinically meaningful improvement in function and pain with acute use.
- Screen worker for depression (e.g., Patient Health Questionnaire-9 [PHQ-9] or other validated tools) to identify potential comorbid conditions which may impact response to opioid treatment. If the worker's history suggests post-traumatic stress disorder (PTSD), administer the 4-item Primary Care (PC)-PTSD screen (www.integration.samhsa.gov/clinical-practice/PC-PTSD.pdf).
- Screen for opioid risk (e.g., Opioid Risk Tool; the Screener and Opioid Assessment for Patients with Pain-Revised [SOAPP-R]; Diagnosis, Intractability, Risk, Efficacy [DIRE]; or CAGE-AID). If the worker has current substance use disorder (excluding nicotine) or a history of opioid use disorder, opioid use beyond the acute phase is rarely indicated.
- Administer a baseline urine drug test (UDT). If results reveal "red flags" such as the *confirmed* presence of cocaine, amphetamines or

alcohol, opioid use beyond the acute phase is not indicated (see AMDG Guideline, Appendix D at www.agencymeddirectors.wa.gov/Files/OpioidGdline.pdf). Unless cannabis use disorder is diagnosed, the presence of cannabis on a UDT does not preclude the use of opioids.
- Re-examine and consider discontinuation or taper of concurrent sedative-hypnotics and/or benzodiazepines.

During the subacute phase, providers should review the effects of opioid therapy on pain and function to determine whether opioid therapy should continue. Opioids should be discontinued during this phase if:

- There is no clinically meaningful improvement in function when compared to function measured during the acute phase.
- Treatment resulted in a severe adverse outcome.
- Worker has a current substance use disorder (excluding nicotine).
- Worker has a history of opioid use disorder (with rare exceptions).

Opioids in the Chronic Phase

If opioids are to be prescribed beyond 12 weeks post-injury or post-surgery, the provider must have received prior authorization from the department. With the exception of catastrophic injuries, the provider must document the following before L&I or insurer can authorize payment for opioids during the chronic phase:

- Clinically meaningful improvement in function (≥30%) has been established with opioid use in the acute or subacute phase.
- Failure of trials of reasonable alternatives to opioids.
- Signed treatment agreement (pain contract).
- A time-limited treatment plan, addressing whether chronic opioid therapy is likely to improve the worker's vocational recovery (e.g., work hardening, vocational services).
- Consultation with a pain management specialist if the worker's dose is above 120 mg/d morphine equivalent dose (MED) and there is no CMIF. Additional appropriate consultations are recommended if the worker has a co-morbid substance use or poorly controlled mental health disorder.
- Worker has no contraindication to the use of opioids.
- No evidence or likelihood of having serious adverse outcomes from opioid use.

During the chronic phase, providers should routinely review the effects of opioid therapy on function to determine whether opioid therapy should continue. COT focused only on reducing pain intensity can lead to rapidly escalating dosage with deterioration in function and quality of life. Prescribers should also continue to check the PMP and administer UDTs based on risk, in accordance with AMDG recommendations and DOH regulations. Because COT is associated with substantial risk for harm, opioid prescribing or dose increases that do not result in CMIF is considered not proper and necessary in the Washington State workers' compensation system.

Continued coverage of COT will depend on the prescriber documenting the following:

- CMIF is maintained, or pain interference with function score is ≤4 with stable dosing. If COT dose is increased, CMIF must be demonstrated in response to the dose change.
- A current signed treatment agreement.
- Worker has no relative contraindication to the use of opioids.
- No evidence of serious adverse outcomes from opioid use.
- Consultation with a pain management specialist if the worker's dose is above 120 mg/d MED and there is no CMIF. Additional appropriate consultations are recommended if the worker has a co-morbid substance use or poorly controlled mental health disorder.
- No aberrant behavior is identified by PMP or UDT.

Prescribers should discontinue opioids and L&I or insurer will not pay for opioids if all the above criteria are not met. Please see the "Discontinuing COT" section below for discontinuing opioids.

Opioids for Catastrophic Injuries

Catastrophic injuries such as severe burns, crush or spinal cord injury in which significant recovery of physical function is not expected are exempt from the above coverage criteria. For catastrophic injuries, the department or insurer may cover COT when the prescriber has documented the following:

- A current signed treatment agreement
- Stable opioid dose at or below 120 mg/d MED

- When opioid dose is above 120 mg/d MED, a consultation with a pain specialist before further dose escalation
- Worker has no relative contraindication to the use of opioids
- No evidence of serious adverse outcomes from opioid use
- No aberrant behavior identified by PMP or UDT

Managing Surgical Pain in Workers on COT

Managing pain in workers on COT who are undergoing elective surgeries presents unique challenges and requires a coordinated treatment plan for pain management prior to surgery. This requires a collaborative effort involving the surgeon, anesthesiologist, pain management specialist, attending provider (AP) and the worker.

A pre-operative evaluation is recommended, preferably by an anesthesiologist, one to two weeks prior to surgery. This should include the worker's current opioid dose (both prescribed and actually taken) and a thorough medical history that includes mental health and substance use disorder information. Accurate dosage information is especially important for planning peri-operative pain management, yet only 9% of patients taking opioids preoperatively have dosage information in the chart. The evaluator should also check the opioid prescribing history in the PMP. The following recommendations will help manage the worker's pain and minimize their risk associated with surgery.

Before surgery (pre-operatively), the surgeon and AP should:

- Have a coordinated treatment plan for managing surgical pain, including identifying the post-operative opioid prescriber.
- Obtain a pre-operative anesthesia consult, as above. Workers on buprenorphine need special anesthesia care and should have a consult at least 2 weeks before surgery.
- Access the PMP and review the worker's controlled substance history to get accurate information on opioid dose and concurrent medication use. Provider should discuss any apparent discrepancies with the worker.
- Prepare the worker for elective surgery by setting appropriate expectations for pain management. Workers need reassurance that their pain management needs will be met, and they need to know that their opioid use is expected to return to the pre-operative dose, or less, following surgery.
- Consider an opioid taper, but this is not required. Avoid escalating opioid dose before surgery.
- Avoid prescribing new benzodiazepines or sedative-hypnotics.
- Consider a consult with a pain management specialist before surgery for workers on high dose opioids or who have co-morbid mental health or substance use disorder.

Day of surgery (intra-operatively), the anesthesiologist should:

- Use anti-inflammatories, acetaminophen or both, if not contraindicated.
- Continue pre-operative opioids to decrease the risk of withdrawal symptoms and use regional blocks, if appropriate.
- Consider the use of other non-opioid analgesic adjuncts (e.g., gabapentin, ketamine or lidocaine) for opioid-sparing effects.

After surgery (post-operatively), the surgeon or hospitalist and AP should:

- Continue pre-operative opioids, with extra analgesia for acute pain via patient-controlled analgesia (PCA) while hospitalized.
- Use care when transitioning from PCA to oral opioids. DO NOT perform a "straight" conversion from intravenous (IV) to oral opioid because of a lack of complete cross-tolerance.
- Expect the worker to need more time than other patients to stabilize pain control after transitioning to oral opioids.
- Discharge the worker on the same pre-operative opioid regimen and only supplement with short-acting (not extended-release) opioids for post-operative pain.
- Do not prescribe long-acting or extended-release opioids for post-operative pain unless the worker was previously maintained on these drugs.
- Avoid new sedative-hypnotics and benzodiazepines.
- Taper total opioids to pre-operative dose or lower by 6 weeks.
- A specialist may be needed for workers on high dose opioids or who have co-morbid mental health or substance use disorder.

Discontinuing COT

Discontinuation of opioids frequently improves function and quality of life and usually does not lead to increased pain levels. In most cases, it is best to taper opioids off completely.

Case Definition – When to Discontinue COT

- Worker or AP requests opioid taper OR
- Worker is maintained on opioids for at least 3 months and there is no sustained CMIF, as measured by validated instruments OR
- Worker's risk from continued treatment outweighs benefit OR
- Worker has experienced a severe adverse outcome or overdose event OR
- Evidence of aberrant behavior (inconsistent urine drug test result, lost prescriptions, multiple requests for early refills, multiple prescribers, unauthorized dose escalation, apparent intoxication, etc.) OR
- Use of opioids is not in compliance with DOH's pain management rules, L&I's rules, AMDG Guideline or L&I's Guideline for Prescribing Opioids to Treat Pain in Injured Workers.

STEP 1: Discontinuing Opioids in a Community Care Setting

In most cases, workers who are not on chronic high dose opioids or who do not have comorbid substance use disorder or a significant mental health disorder may be tapered in a straightforward manner. A gradual taper of approximately 10% per week (see AMDG Guideline, Tapering or Discontinuing Opioids and Appendix H at www.agencymeddirectors.wa.gov/Files/OpioidGdline.pdf) can be carried out by the AP. Adjuvant agents like clonidine and psychological support such as cognitive behavioral therapy can be provided to assist with the taper process. The department or insurer may also authorize temporary coverage of buprenorphine or buprenorphine/naloxone to assist with the tapering process (see L&I coverage policy). The AP may also seek consultative assistance from a pain management specialist.

STEP 2: Discontinuing Opioids in an Intensive Setting

For those workers who have failed step 1 or who are at high risk for failure due to high dose, concurrent benzodiazepine use, or co-morbid substance use or mental health disorder, the prescriber should consider seeking consultative assistance from a pain management specialist, a structured intensive multidisciplinary program (SIMP) provider or addiction medicine specialist. Adjuvant agents and psychological support can be provided to assist with the taper process. The department or insurer may also authorize temporary coverage of buprenorphine or buprenorphine/naloxone to assist with the tapering process (see L&I coverage policy). In these situations, formal inpatient detoxification and/or a 4-week SIMP treatment program may be required.

Due to the lack of high quality evidence of safety and comparative efficacy, ultra rapid detoxification (e.g., within three days), using antagonist drugs with or without sedation, will not be covered.

Additional Services

If a worker has failed Steps 1 and 2, AND meets the DSM-V criteria for opioid use disorder, the department or insurer may cover up to six months of addiction treatment through a licensed chemical dependency treatment center as an aid to recovery. A list of treatment centers certified by the Division of Behavior Health and Recovery is available at www.dshs.wa.gov/dbhr/dadirectory.shtml.

Refer to the original guideline document for more information about additional services.

Treatment Options for Opioid Use Disorder

- Medication assisted treatment
  - Buprenorphine (Subutex®, Suboxone®)
  - Methadone
  - Naltrexone (Depade®, Revia®, Vivitrol®)
  - Drug-free outpatient treatment
- Residential treatment

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Chronic non-cancer pain

Other Disease/Condition(s) Addressed

- Anxiety
- Bipolar disorder
- Borderline personality disorder
- Depression
- Post traumatic stress disorder (PTSD)
- Substance-related disorders

Guideline Category

Evaluation

Management

Rehabilitation

Risk Assessment

Treatment

Clinical Specialty

Anesthesiology

Emergency Medicine

Family Practice

Internal Medicine

Neurological Surgery

Neurology

Orthopedic Surgery

Pharmacology

Physical Medicine and Rehabilitation

Surgery

Intended Users

Advanced Practice Nurses

Health Care Providers

Health Plans

Managed Care Organizations

Nurses

Pharmacists

Physician Assistants

Physicians

Substance Use Disorders Treatment Providers

Utilization Management

Guideline Objective(s)

- To supplement the Washington State Agency Medical Directors' Group (AMDG) *Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain* (2010) and the Washington State Department of Health (DOH) pain management rules
- To provide information specific to treating injured workers covered by Washington State workers' compensation system
- To carefully assess the risk/benefit of prescribing opioids for injured workers, particularly if they are being considered for chronic (>3 months) use

Target Population

Injured and ill workers with acute, subacute, and chronic noncancer pain

Interventions and Practices Considered

1. Measuring the impact of opioid use by tracking the worker's pain and function at regular intervals using a validated tool
2. Cautious and appropriate prescription of opioids in the acute, subacute, and chronic phases of pain
    - Documenting doses, pain relief, and functional status of the worker
    - Using tools to assess risk, such as the Prescription Monitoring Program, urine drug tests, and screening tools for depression and opioid risk
    - Monitoring for adverse outcomes
    - Reassessing opioid prescribing regularly and at predetermined phases of treatment and discontinuing therapy if indicated
3. Managing surgical pain in workers on chronic opioid therapy
    - Preoperative medical and anesthesia consult
    - Intraoperative management of pain
    - Postoperative maintenance and tapering of opioid dose
4. Appropriate discontinuation of opioid therapy

Major Outcomes Considered

- Functional improvement
- Pain control
- Safety and efficacy of opioid use
- Adverse outcomes of opioid use

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Literature searches were conducted mostly in October and November of 2011, by department medical research staff. Additional searches were conducted as requested by the Industrial Insurance Medical Advisory Committee (IIMAC) Subcommittee members. Searches were limited to: humans, English, all adults, and published in 1990 or later. Excluded were cancer pain, adolescents, treatment groups of <10, and pregnancy-related articles.

PubMed was the main database searched. Search terms used were: opioid therapy, prescription opioids, chronic opioid therapy, comorbidities, tapering opioids, pre-operative opioids, and post-operative opioids. Specific comorbidity search terms were: depression, anxiety, sleep apnea, sleep disorder, COPD, cardiac arrhythmias, mood disorders.

Number of Source Documents

Ninety-five source documents were reviewed; 41 were cited.

Methods Used to Assess the Quality and Strength of the Evidence

Expert Consensus (Committee)

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

The committee used the American Academy of Neurology (AAN) rating scheme to assess the strength of the evidence. Refer to the AAN Clinical Practice Guideline Process Manual, http://www.aan.com/globals/axon/assets/9023.pdf.

Methods Used to Analyze the Evidence

Systematic Review

Description of the Methods Used to Analyze the Evidence

Not stated

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

This guideline was developed in 2011-2012 by the Industrial Insurance Medical Advisory Committee (IIMAC) and its subcommittee on chronic non-cancer pain.

Guideline development uses the best available scientific evidence and expert consensus. The process can be described in the following steps:

1. Once a guideline or group of guidelines is selected, a subcommittee is formed with selected IIMAC members, practicing physician specialists, and contracted utilization review physicians. Other clinical specialists may be invited to give presentations to help inform the subcommittee.
2. A systematic review and summary of the relevant peer reviewed medical literature is done and is presented to the subcommittee for their review. Claim and billing data from Labor & Industries may also be reviewed.
3. The findings from the literature review are categorized and adapted into the first draft following these general areas (this will vary slightly for each guideline):

- Introduction
- Establishing work-relatedness
- Making the diagnosis
  - Case definition (symptoms and signs)
  - Relevant diagnostic tests (e.g., imaging, electrodiagnostic, lab, etc.)
- Treatment
  - Conservative treatment
  - Surgical treatment
- Return to work (RTW)
  - Early assessment, including occupational health quality indicators
  - Returning to work following surgery
- Worksheets, tools, forms
- Guideline summary or algorithm for professional nurse reviewers

4. Subcommittee members critique and revise the guideline based on what is most useful for the clinician in diagnosing and treating the condition in question. Additional expertise, consultation, and literature searches may also be added. The result is a second draft guideline that is then shared with the full advisory committee to obtain their input.

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

- After the full advisory committee has given their input and any recommended changes are made, the third draft guideline is posted on the web and distributed via a provider listserv for public review and comment.
- Once all public comments are received and reviewed, responses are provided by the subcommittee. Both comments and responses are posted on the web.
- The subcommittee may make further revisions to the draft guideline based on public input and any other information they have received. This then results in a fourth draft.
- The fourth draft is presented to the full advisory committee in an open public meeting. Oral comments are invited from the public, and the full committee may recommend further changes, potentially creating a fifth and final draft.
- Once the full committee makes the advisory recommendation to adopt the guideline, it becomes final and is again posted on the web and distributed via the provider listserv.
- Labor & Industries (L&I) then posts on the web a Provider Bulletin announcing the new or revised guideline and distributes it via the provider listserv.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is not specifically stated for each recommendation.

This guideline is based on the best available clinical and scientific evidence from a systematic review of the literature and a consensus of expert opinion.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Implementation of this guideline will have many benefits including: decreasing deaths from opioids, decreasing non-fatal adverse effects and outcomes of opioid use, decreasing risk of disability, providing appropriate pain relief accompanied by functional improvement, helping providers and injured workers assess function and pain in a meaningful way, guiding providers in appropriate prescribing of opioids, decreasing the numbers of workers on long-term opioids, decreasing the numbers of workers with certain risky co-morbid conditions who receive opioids.

Potential Harms

Opioid Therapy

- In some cases, the use of opioids for work-related injuries may actually increase the likelihood of disability. Receiving more than a one week supply of opioids or two or more opioid prescriptions soon after an injury doubles a worker's risk of disability at one year post-injury, compared with workers who do not receive opioids.
- In addition to the risk of mortality, chronic opioid therapy (COT) is associated with significant risk of non-fatal adverse outcomes. COT may result in tolerance to its analgesic effects. The traditional prescribing practice was to use escalating doses to overcome this effect. However, evidence is accumulating that chronic, high-dose opioid use may lead to the development of abnormal pain sensitivity (opioid-induced hyperalgesia). Dose escalation that does not improve pain and function can lead to increased risk for severe adverse outcomes. These include inhibition of endogenous sex hormone production, neonatal abstinence syndrome, central sleep apnea, opioid use disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders V [DSM-V]), overdose and death.
- There is a risk of abuse of opioids, especially after long-time use.

Methadone

- Deaths, cardiac and respiratory, have been reported during initiation and conversion of pain patients to methadone treatment from treatment with other opioid agonists. It is critical to understand the pharmacokinetics of methadone when converting patients from other opioids.
- Respiratory depression is the chief hazard associated with methadone administration. Methadone's peak respiratory depressant effects typically occur later, and persist longer than its peak analgesic effects, particularly in the early dosing period. These characteristics can contribute to cases of iatrogenic overdose, particularly during treatment initiation and dose titration.
- In addition, cases of QT interval prolongation and serious arrhythmia (torsades de pointes) have been observed during treatment with methadone. Most cases involve patients being treated for pain with large, multiple daily doses of methadone, although cases have been reported in patients receiving doses commonly used for maintenance treatment of opioid addiction.
- Methadone treatment for analgesic therapy in patients with acute or chronic pain should only be initiated if the potential analgesic or palliative care benefit of treatment with methadone is considered and outweighs the risks.

Contraindications

Contraindications

Workers with current substance use disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) (excluding nicotine) should not receive chronic opioid therapy (COT). Workers with a history of opioid use disorder should only receive COT under exceptional circumstances.

Drugs and Drug Combinations to Avoid

- Parenteral opioids in an outpatient setting
- Meperidine for chronic pain
- Methadone for acute or break-through pain
- Long-acting or extended-release opioids (e.g. Oxycontin®) for acute pain or post-operative pain in an opioid-naive worker

Qualifying Statements

Qualifying Statements

- This guideline is a supplement to both the Agency Medical Directors' Group (AMDG) Guideline and the Department of Health's (DOH) pain management rules, and provides information specific to treating injured workers covered by Washington State workers' compensation.
- This new guideline replaces the department's current guidelines on opioids: *Guidelines for outpatient prescription of controlled substances, Schedules II-IV, for workers on time-loss*, and *Guidelines for outpatient prescription of oral opioids for injured workers with chronic, non-cancer pain*.

Implementation of the Guideline

Description of Implementation Strategy

Most guidelines are implemented within the utilization review (UR) program. Labor & Industries (L&I) guidelines have priority over other proprietary guidelines and criteria that may exist. Where L&I guidelines are not available, proprietary ones may be used. Reviewers apply each guideline as a standard for the majority of requests in the Washington workers' compensation program. For the minority of workers who appear to fall outside of the guideline and whose complexity of clinical findings exceeds the specificity of the guideline, further review by a physician is conducted.

When a surgical procedure is requested for a patient who meets the guideline criteria, the reviewer will recommend approval to the claim manager. If the criteria are not met, the request will be referred to a physician consultant who will review the patient's file, offer to discuss the case with the requesting physician, and make a recommendation to the claim manager. The flexibility built into this decision making process is important in two ways. First, it enables the Washington State Industrial Insurance Medical Advisory Committee (IIMAC) to develop surgical indications fairly quickly. Second, it plays a major role in legitimizing the work of the subcommittee in the eyes of practicing physicians in Washington.

Completed guidelines are communicated to practicing physicians via L&I's website and through its provider listserv (to join, go to: http://www.lni.wa.gov/Main/Listservs/Provider.asp). Education and training will be provided to reviewers and staff to ensure their proper application within the UR program. Where possible, continuing medical education (CME) credits may be offered.

The guideline has been published on the Labor and Industries website, medical treatment guidelines page: http://www.lni.wa.gov/ClaimsIns/Files/OMD/MedTreat/FINALOpioidGuideline010713.pdf .

The guideline will be implemented at the Department of Labor and Industries between January 1 and June 30 of 2013. New rules are being created to guide opioid prescribing, and it is anticipated the rules will be complete and in effect on July 1, 2013. The rules are being created following the usual agency process, with a committee headed by the pharmacy manager and the rules coordinator for the Office of the Medical Director.

Claim managers and occupational nurse consultants will be trained on the use of the guideline. This will be done by a committee including the pharmacy manager, the health policy staff, occupational nurse representatives, and claims training staff. Implementation may take the form of a different review process from that currently used to review requests for opioids.

New tools are being created for implementation, including a new form for providers which will replace the current Opioid Progress Report. New tools may also include checklists, resources and staff training/competency manuals.

Providers in the state are being notified by listservs, meetings and conferences. The guideline has been presented at professional association meetings and conferences, and shared with other in-state and out-of-state agencies who are involved in preventing morbidity and mortality from opioid use.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Safety

Identifying Information and Availability

Bibliographic Source(s)

Washington State Department of Labor and Industries. Guideline for prescribing opioids to treat pain in injured workers. Olympia (WA): Washington State Department of Labor and Industries; 2013 Jul 1. 19 p. [41 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2013 Jul 1

Guideline Developer(s)

Washington State Department of Labor and Industries - State/Local Government Agency [U.S.]

Source(s) of Funding

The Washington State Department of Labor and Industries is a public state agency and did not receive outside funding.

Guideline Committee

Washington State Department of Labor and Industries (L&I), Industrial Insurance Medical Advisory Committee, Subcommittee on Chronic Pain and Opioid Use

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Financial Disclosures/Conflicts of Interest

The Washington State Department of Labor and Industries is a public state agency and has no conflicts of interest to report.

Guideline Status

This is the current release of the guideline.

Guideline Availability

Electronic copies: Available from the Washington State Department of Labor and Industries Web site .

Availability of Companion Documents

The following are available:

- Medical treatment guidelines for Washington Workers' Compensation. Washington State Department of Labor and Industries. Guideline process. Electronic copies: Available in Portable Document Format (PDF) from the Washington State Department of Labor and Industries Web site .
- Interagency guideline on opioid dosing for chronic non-cancer pain: an educational aid to improve care and safety with opioid therapy. 2010 update. Olympia (WA): Agency Medical Directors; 2010. 59 p. Electronic copies: Available in PDF from the Agency Medical Directors Web site .

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI Institute on April 8, 2013. This summary was updated by ECRI Institute on October 28, 2013 following the U.S. Food and Drug Administration advisory on Acetaminophen. This summary was updated by ECRI Institute on June 2, 2016 following the U.S. Food and Drug Administration advisory on Opioid pain medicines.

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